

Form 5500-SF Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Short Form Annual Return/Report of Small Employee Benefit Plan This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ► Complete all entries in accordance with the instructions to the Form 5500-SF.	OMB Nos. 1210-0110 1210-0089 <div style="border: 1px solid black; padding: 5px; text-align: center; font-weight: bold;">2013</div> This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2013 or fiscal plan year beginning <u>01/01/2013</u> and ending <u>12/31/2013</u>	
A This return/report is for:	<input checked="" type="checkbox"/> a single-employer plan <input type="checkbox"/> a multiple-employer plan (not multiemployer) <input type="checkbox"/> a one-participant plan
B This return/report is:	<input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)
C Check box if filing under:	<input type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> DFVC program <input type="checkbox"/> special extension (enter description)

Part II	Basic Plan Information —enter all requested information		
1a Name of plan PEDIATRIC NEUROLOGY OF HUDSON VALLEY P.L.L.C. PROFIT SHARING PLAN		1b Three-digit plan number (PN) ►	002
		1c Effective date of plan 01/01/1996	
2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) PEDIATRIC NEUROLOGY OF HUDSON VALLEY, P.L.L.C. P.O. BOX 1195 NEW CITY, NY 10956-8195		2b Employer Identification Number (EIN) <u>13-3949843</u>	
		2c Sponsor's telephone number 845-627-1806	
		2d Business code (see instructions) 621111	
3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor Name <input type="checkbox"/> Same as Plan Sponsor Address		3b Administrator's EIN	
		3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report. a Sponsor's name		4b EIN	
		4c PN	
5a Total number of participants at the beginning of the plan year		5a	6
b Total number of participants at the end of the plan year		5b	6
c Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)		5c	6
6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
b Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.			
c If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not determined	

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.		
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
Preparer's name (including firm name, if applicable) and address; include room or suite number (optional)			Preparer's telephone number (optional)

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	830458	1178426
b Total plan liabilities	7b		
c Net plan assets (subtract line 7b from line 7a)	7c	830458	1178426
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	63451	
(2) Participants	8a(2)	0	
(3) Others (including rollovers)	8a(3)	61066	
b Other income (loss)	8b	225730	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		350247
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d		
e Certain deemed and/or corrective distributions (see instructions)	8e		
f Administrative service providers (salaries, fees, commissions)	8f	0	
g Other expenses	8g	2279	
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		2279
i Net income (loss) (subtract line 8h from line 8c)	8i		347968
j Transfers to (from) the plan (see instructions)	8j		

Part IV Plan Characteristics

- 9a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
2E
- b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

Part V Compliance Questions

10 During the plan year:	Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a	X	
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b	X	
c Was the plan covered by a fidelity bond?	10c	X	
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d	X	
e Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)	10e	X	
f Has the plan failed to provide any benefit when due under the plan?	10f	X	
g Did the plan have any participant loans? (If "Yes," enter amount as of year end.)	10g	X	
h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h	X	
i If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	10i		

Part VI Pension Funding Compliance

11 Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and line 11a below)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
11a Enter the unpaid minimum required contribution for current year from Schedule SB (Form 5500) line 39	11a
12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? ..	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)	
a If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiver. Month _____ Day _____ Year _____	
If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.	
b Enter the minimum required contribution for this plan year	12b

c Enter the amount contributed by the employer to the plan for this plan year	12c	
d Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount).....	12d	
e Will the minimum funding amount reported on line 12d be met by the funding deadline?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	

Part VII Plan Terminations and Transfers of Assets

13a Has a resolution to terminate the plan been adopted in any plan year?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If "Yes," enter the amount of any plan assets that reverted to the employer this year	13a
b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
c If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)	
13c(1) Name of plan(s):	13c(2) EIN(s)

Part VIII Trust Information (optional)

14a Name of trust PEDIATRIC NEUROLOGY OF HUDSON VALLE	14b Trust's EIN 133934638
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Form 5500-SF

Department of the Treasury
Internal Revenue ServiceShort Form Annual Return/Report of Small Employee
Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

► Complete all entries in accordance with the instructions to the Form 5500-SF.

OMB Nos. 1210-0110
1210-0089

2013

This Form is Open to Public
InspectionDepartment of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Part I Annual Report Identification Information

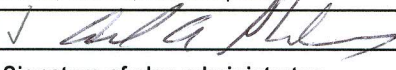
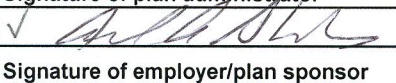
For calendar plan year 2013 or fiscal plan year beginning	01/01/2013	and ending	12/31/2013
A This return/report is for:	<input checked="" type="checkbox"/> a single-employer plan	<input type="checkbox"/> a multiple-employer plan (not multiemployer)	<input type="checkbox"/> a one-participant plan
B This return/report is:	<input type="checkbox"/> the first return/report	<input type="checkbox"/> the final return/report	
	<input type="checkbox"/> an amended return/report	<input type="checkbox"/> a short plan year return/report (less than 12 months)	
C Check box if filing under:	<input type="checkbox"/> Form 5558	<input type="checkbox"/> automatic extension	<input type="checkbox"/> DFVC program
	<input type="checkbox"/> special extension (enter description)		

Part II Basic Plan Information --- enter all requested information

1a Name of plan PEDIATRIC NEUROLOGY OF HUDSON VALLEY P.L.L.C. PROFIT SHARING PLAN	1b Three-digit plan number (PN) ► 002
	1c Effective date of plan 01/01/1996
2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) PEDIATRIC NEUROLOGY OF HUDSON VALLEY, P.L.L.C. P.O. BOX 1195 US NEW CITY NY 10956-8195	2b Employer Identification Number (EIN) 13-3949843
	2c Sponsor's telephone number (845) 627-1806
	2d Business code (see instructions) 621111
3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor Name <input type="checkbox"/> Same as Plan Sponsor Address	3b Administrator's EIN
	3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report. a Sponsor's name	4b EIN
	4c PN
5a Total number of participants at the beginning of the plan year	5a 7
b Total number of participants at the end of the plan year	5b 6
c Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)	5c 6
6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
b Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.	
c If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not determined

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE		3/30/14	ARIEL SHERBANY, M.D.
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		3/30/14	ARIEL SHERBANY, M.D.
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
Preparer's name (including firm name, if applicable) and address; include room or suite number (optional)			Preparer's telephone number (optional)

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	830,458	1,178,426
b Total plan liabilities	7b		
c Net plan assets (subtract line 7b from line 7a)	7c	830,458	1,178,426
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	63,451	
(2) Participants	8a(2)	0	
(3) Others (including rollovers)	8a(3)	61,066	
b Other income (loss)	8b	225,730	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		350,247
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d		
e Certain deemed and/or corrective distributions (see instructions) ...	8e		
f Administrative service providers (salaries, fees, commissions)	8f	0	
g Other expenses	8g	2,279	
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		2,279
i Net income (loss) (subtract line 8h from line 8c)	8i		347,968
j Transfers to (from) the plan (see instructions)	8j		

Part IV Plan Characteristics

- 9a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
2E
- b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

Part V Compliance Questions

10 During the plan year:		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a		X	
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		X	
c Was the plan covered by a fidelity bond?	10c		X	
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d		X	
e Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)	10e		X	
f Has the plan failed to provide any benefit when due under the plan?	10f		X	
g Did the plan have any participant loans? (If "Yes," enter amount as of year end.)	10g		X	
h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		X	
i If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	10i			

Part VI Pension Funding Compliance

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(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)		
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c Enter the amount contributed by the employer to the plan for this plan year	12c	
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e Will the minimum funding amount reported on line 12d be met by the funding deadline?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	

Part VII Plan Terminations and Transfers of Assets

13a Has a resolution to terminate the plan been adopted in any plan year?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
If "Yes," enter the amount of any plan assets that reverted to the employer this year	13a	
b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?.....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
c If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)		
13c(1) Name of plan(s):	13c(2) EIN(s)	13c(3) PN(s)

Part VIII Trust Information (optional)

14a Name of trust PEDIATRIC NEUROLOGY OF HUDSON VALLE	14b Trust's EIN 13-3934638
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5500-SF Electronic Filing Authorization

Plan Name: PEDIATRIC NEUROLOGY OF HUDSON VALLEY P.L.L.C. PROFIT SHARING PLAN
EIN/PN: 13-3949843/002
Plan Year: 01/01/2013 - 12/31/2013

I hereby authorize Everett Berger to electronically file the above return with the US Department of Labor's Electronic Filing Acceptance System (EFAST).

I have signed Form 5500-SF for this return and understand a scanned copy of this return bearing my manual signature will be included in the electronic filing and posted on the US Department of Labor's internet site for public disclosure.

Plan Administrator


✓ 

(sign)

✓ 3/30/14

(date)

Plan Sponsor

✓ 

(sign)

✓ 3/30/14

(date)